14 February 1978

MEMORANDUM FOR THE VICE CHIEF OF NAVAL OPERATIONS

Subj: Organization for Health Care Services Study

Ref: (a) VCNO Memo Ser 09/001364 of 30 Sep 1977

Encl: (1) Completed Study: Organization for Health Care Services

1. By reference (a) you tasked me to study the organizational relationships within the Navy pertaining to health care services.

2. Enclosure (1) is the completed study. Additional copies are available for distribution upon your approval.

Very respectfully,

G. E. SYNHORST
RADM, USN (RET.)

ORGANIZATION FOR HEALTH CARE SERVICES

A STUDY CONDUCTED BY THE

OFFICE OF ORGANIZATIONAL APPRAISAL

(OP-09E)

31 JANAURY 1978

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PART 1

INTRODUCTION

As a result of the recent attention focused on the critical problems in military health care services, the Vice Chief of Naval Operations has expressed concern that the magnitude of the problems specifically related to the Navy may not have been fully outlined to the CNO. In consonance with a SECNAV-directed study of the organization and management of the headquarters of the Bureau of Medicine and Surgery and a CNO-directed review of the adequacy of staffing and distribution of medical personnel throughout the Navy, the VCNO tasked the Office of Organizational Appraisal, OP-09E, to conduct a study and develop recommendations concerning the following points:

TASK I - Organizational Alignment for Health Care Services in OPNAV

TASK II - Increased Utilization of MSC, Navy Line or Civilian Administrators at Regional Medical Centers

TASK III - Posture of the Navy with Respect to Current OSD Initiatives

The tasking letter is included herein as Appendix A and Tasks I through III are discussed and developed in Parts 3 through 5 respectively of this study. The resultant summary of recommendations is contained in Part 2.

Many studies in the health care services area have been conducted; a compendium is included as Appendix B. These formed the basic data bank of this study. A study team was formed of representatives of the affected OPNAV codes. The study commenced on 1 November 1977. The target completion date was 16 December 1977. The membership, listed below, offered a mixture of one line officer, 2 Medical Corps officers and 3 Medical Service Corps officers:

Director	RADM Gerald E. Synhorst (Ret.)	OP-09E

Representatives

OP-01	LCDR James D. Smith (2300)	OP-100F3
OP-04	CDR Lawrence L. Biesiadny (2300)	OP-415
OP-05	CAPT Paul S. Daly (1310)	OP-597

OP-098	CAPT Roger G. Ireland (2100)	OP-098E
OP-099	CAPT Stanley J. Kreider (2100)	OP-099M
OP-09H	LT Dale A. Knee (2300)	OP-09H1

A plan of action and milestones (Appendix C) was proposed and approved at the first meeting. However, because of the considerable volume of literature, required research and desire to avoid redundancy with ongoing studies, a request for extention of the completion date to 31 January 1978 was approved on 2 December 1977 (Appendix D).

PART 2

SUMMARY OF RECOMMENDATIONS

I-1. CNO establish a new DMSO, OP-093, to be entitled the Office of the Surgeon General directed by the Surgeon General on a double hat basis with the Chief of the Bureau of Medicine and Surgery.

I-2. CNO (OP-090) revise the Department of the Navy Programming Manual and current POM procedures to reassign resource sponsorship for medical programs to the new OP-093.

I-3. Surgeon General, in coordination with OP-09B, arrange to have a mission and function statement for the proposed OP-093 promulgated in the OPNAV Organization Manual. Proposed mission and function statements are listed on pages 12 and 13 of this Study.

I-4. Surgeon General with assistance of OP-09B arrange to have requisite OPNAV and BUMED billets, ceiling points and personnel transferred to proposed new OP-093.

I-5. Surgeon General, as OP-093, arrange to have regular DMC appointments with the CNO/VCNO.

I-6. Surgeon General, as OP-093, make arrangements to schedule full-fledged semi-annual CEB presentations on the status of the Navy Health Care System.

I-7. VCNO terminate the OPNAV staff practice of developing medical mission requirements, accomplishing routine medical programming and formulating medical policy by ad hoc study teams. These efforts are really day to day staff functions.

II-1. The Chief, Bureau of Medicine and Surgery continue to assign only Medical Corps officers to command Navy Regional Medical Centers.

II-2. The Chief, Bureau of Medicine and Surgery accomplish any further non-physician substitutions within the Navy Regional Medical Center system utilizing primarily Medical Service Corps and Nurse Corps officers where such substitution in senior administrative billets is possible.

II-3. CNO recommend to the Secretary of the Navy that appropriate legislative action be requested and supported to amend Title 10 restrictions addressing flag representation in the Medical Service Corps. Request one Medical Service Corps flag billet. Compensation for this MSC flag billet should come from Medical Department assets.

II-4. The Chief, Bureau of Medicine and Surgery, in coordination with the Chief of Naval Personnel and the Chief of Naval Education and Training, establish formal career paths for some Medical Corps and Medical Service Corps officers which would include a formal training program in health care administration and/or hospital administration.

II-5. The Chief of Naval of Personnel develop for approval by the CNO a time phased plan to enhance the Medical Service Corps retention program and remove any unnecessary roadblocks in the Medical Service Corps promotion policy.

III-1. The CNO/VCNO insure concerted Navy input, in the medical area, to the OSD reorganization studies taking place under the guidelines of the Presidential Reorganization Project. Two studies are involved, the Resources Study (Rice Study) and the Defense Department Headquarters Study (Ignatius Study). Particular accent should be placed upon Navy-Marine medical contingency and wartime requirements as well as peacetime training therefor.

III-2. The CNO support the Defense Health Council concept and the Navy's Surgeon General participation therein. Other mechanisms intended to centralize control over medical matters in OSD would probably have a more adverse affect on the Navy Secretary's and the CNO's ability to do medical contingency planning.

III-3. The VCNO:

a. Insure constant, active participation by the Surgeon General in deliberations of the Defense Health Council, which appears to be a key OSD entity for control of military health care.

b. Insure awareness of DHC deliberations through both post-meeting discussions with the Surgeon General as well as personal, bi-annual updates for the CNO (along with appropriate DCNOs and DMSOs).

c. Make both formal and informal representation to SECNAV that all DHC recommendations be staffed through the SECDEF/SECNAV command chain prior to any decisions.

III-4. The Surgeon General:

a. In cooperation with the other Surgeons General, insure the DHC places greater relative stress upon medical readiness and contingency requirements as separate (although related) from peacetime care of the beneficial population.

b. Insure that his staff is organized to support him rapidly and thoroughly in participations of the DHC, especially in the planning and programming areas.

c. Suggest the DHC and OSD(HA) refrain from encouraging or sponsoring any further studies until a careful review is made of the multitudinous health care studies by OSD and the individual services during the past decade; determine what has been done, what should still be done, and what is presently impossible.

d. As a member of the OPNAV staff, work closely with OP-01/CHNAVPERS and CMC regarding those matters taken up by the Defense Health Council which affect retention, recruiting and morale of uniformed personnel in the Navy Department.

III-5. CHINFO, in view of the strong interest by personnel in the Navy and Marine Corps about medical care for themselves and their dependents, mount a more aggressive public relations campaign to explain the "whys" and "wherefores" of present medical-dental care. Particularly the complex CHAMPUS area should be stressed.